STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 10/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview, and record review the facility failed to accurately transcribe physician orders and properly administer medications for 2 of 6 residents reviewed for medication storage and administration (Residents #50 and #44). The findings included: 1. Resident #50 was admitted to the facility on 01/16/12. He had diagnoses that included glaucoma, and a review of his annual Minimum Data Set (MDS) dated 8/25/15 indicated Resident #50 was cognitively intact. On 10/01/15 at 2:45 PM a review of the facility's medication storage was conducted. During the review it was revealed Resident #50 had a bottle of Pilocarpine 4% drops- one drop to right eye 4 times daily that was dated 09/30/15. A review of Resident #50's Medication Administration Record (MAR) indicated he was ordered Pilocarpine 4% gel-1/2 inch to lower lid of right eye at bedtime. There was no order for Pilocarpine drops and Resident #50 had no Pilocarpine gel in the medication cart. The current pharmacy order indicated Resident #50 should have received Pilocarpine 4% drops- 1 drop to right eye 4 times daily. On 10/01/15 at 3:50 PM an interview conducted with Resident #50 revealed he gets numerous eye drops in his eyes for glaucoma on a daily basis. He stated he did not get an eye gel placed in his eyes. Resident #50 indicated he used to get	F 281		10/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/23/2015

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a gel placed in his eyes, but had not received the gel in a long time. He stated he could not remember how long it had been.
On 10/01/15 at 4:20 PM an interview was conducted with the Director of Nursing (DON). She stated the medication order for Pilocarpine on the MAR, and the Pilocarpine medication that was in the medication cart was different. She revealed the order for Resident #50 indicated he should have received Pilocarpine gel, but the staff had administered Pilocarpine drops. The DON indicated it was her expectation that the nursing staff who administered the medication should have compared the order with the actual medication and realized there was a discrepancy in the orders.
On 10/01/15 at 5:45 PM an interview was conducted with Nurse #2. She revealed she had given Resident #50 the Pilocarpine eye drops at bedtime on multiple occasions. She stated she should have compared the medication order to the actual medication that was supplied. Nurse #2 indicated she had made a mistake and had missed the order.
On 10/01/15 at 4:55 PM an interview was conducted with the facility Medical Director (MD). He stated Resident #50 should have been getting the medication as it was ordered. The MD revealed the facility should have caught the change in the medication when it was changed from the gel to the drops. He stated he did not believe Resident #50 had experienced a change in his eye condition due to the error. He indicated Resident #50 had regular eye exams, and a change in his condition would have been discovered.
On 10/01/15 at 5:30 PM an interview was conducted with the DON. She revealed the medication order had been changed from

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Pilocarpine gel at bedtime to Pilocarpine drops 4 times daily in June of 2014. She states the pharmacy had been sending the drops since that time. The DON indicated the facility had failed to catch the change in the medication order since that time, and Resident #50 had received Pilocarpine drops at bedtime. She stated it was her expectation that the change in the medication order would have been discovered during monthly reconciliations of the MAR's, and the nurses giving the medication should have identified the difference in the order and the available medication when it was administered.

2. Resident #44 was admitted to the facility 07/23/10 with diagnoses which included diabetes and chronic pain.

The current care plan for Resident #44 was last updated 07/16/15 and included a problem area, resident has chronic pain. One of the approaches to this problem area was, administer pain medications.

Review of the medical record and physician progress notes for Resident #44 noted the following:
Resident #44 had been on 300 milligrams (mg) of Neurontin at bedtime (HS) since 12/02/14. On 09/17/15 this order was changed to 100 mg of Neurontin twice a day (BID) and 300 mg at HS. These were entered into the electronic Medication Administration Record (MAR) under two separate entries; the first entry-100 mg of Neurontin scheduled at 8:00 AM and 1:00 PM and, the second entry-300 mg of Neurontin at

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9:00 PM.

On 09/30/15 the physician wrote an order to discontinue the prior orders of Neurontin and ordered Neurontin 300 mg BID. Review of the electronic MAR for Resident #44 on 10/1/15 noted the order for 300 mg of Neurontin BID had been entered on the MAR with administration times listed as 9:00 AM and 9:00 PM. The prior order for 100 mg of Neurontin scheduled at 8:00 AM and 1:00 PM remained on the MAR and the 300 mg dose of Neurontin at 9:00 PM had been discontinued.

On 10/01/15 at 10:52 AM Nurse #3 (the nurse assigned to Resident #44 at the time of the interview) reviewed the electronic MAR of Resident #44 and noted she had initialed the two AM entries for Neurontin on 10/01/15 (300 mg at 9:00 AM and 100 mg at 8:00 AM) which indicated the medication had been administered. Nurse #3 removed the medication for Resident #44 out of the medication cart which included two separate dose packs of Neurontin; a 300 mg dose pack and a 100 mg dose pack of Neurontin. Nurse #3 reviewed the physician orders from 09/30/15 and noted the order to discontinue the prior orders of Neurontin and initiate Neurontin 300 mg BID. Nurse #3 demonstrated how orders are changed in the electronic MAR; noting the nurse had to scroll through the entire electronic MAR (which involved a review of multiple screens) if there was a dose change to find the initial dose. Nurse #3 noted medications were not in any particular order on the MAR; including the same medication if there were multiple entries. Nurse #3 stated although she had initialed both the 100 mg dose of Neurontin at 8:00 AM and 300 mg dose of Neurontin at 9:00 AM she had only given

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Resident #44 300 mg of Neurontin that morning.

On 10/01/15 at 11:00 AM the Assistant Director of Nursing (ADON) joined the discussion and review of the MAR and physician orders for Resident #44. The ADON noted Nurse #4 had taken and processed the change order for the Neurontin on 09/30/15. The ADON stated when orders were changed staff had to scroll through the MAR to ensure there were not multiple entries of an order. The ADON stated the nurse that worked third shift was responsible to do a double check of all orders for accuracy. The ADON reviewed the nursing schedule from 09/30/15 and noted Nurse #5 worked third shift on the unit Resident #44 resided.

On 10/01/15 at 11:15 AM the Director of Nursing (DON) joined the discussion and review of the MAR and physician orders for Resident #44. The DON located the copy of the 09/30/15 Neurontin order for Resident #44 which had been initialed by Nurse #5. The DON stated when initialed; it would indicate the third shift nurse reviewed the MAR in its entirety to ensure the order had been correctly processed. The DON stated the medications do not display on the electronic MAR in any particular order and a nurse would have to scroll through the entire MAR to ensure there were not multiple entries of the same medication when an order was written to discontinue a medication. The DON reviewed the MAR of Resident #44 and noted it appeared Nurse #4 had discontinued the 300 mg dose of Neurontin scheduled at 9:00 PM when the 09/30/15 order was processed. The DON stated Nurse #4 must have missed the 100 mg dose of Neurontin with doses scheduled at 8:00 AM and 1:00 PM when the order change was made on 09/30/15 on the

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electronic MAR. The DON stated Nurse #5 must have also missed the second entry when the order was verified on 09/30/15.

On 10/01/15 at 11:44 AM the physician of Resident #44 stated the dosage of Neurontin should have been changed to provide only 300 mg twice a day. The physician stated had the resident received 400 mg of Neurontin it would not have caused any harm as it was within acceptable dosage levels of the medication.

In an interview on 10/01/15 at 3:57 PM Nurse #4 verified she had worked 09/30/15 and processed the Neurontin order for Resident #44. Nurse #4 stated when the order was processed she would have reviewed the MAR of Resident #44 to discontinue the prior dose. Nurse #4 stated she must have missed the second dose of Neurontin when the order was processed. Attempts to contact Nurse #5 were unsuccessful.